accountability and is required to have an independent audit of that system completed annually. This requirement is below.

Disclosure of Financial Records and Processes:

The PIHP shall establish and maintain an accounting system in accordance with generally accepted accounting principles (GAAP). The costs properly applicable to Title XIX State Plan services, distinct from Title XIX 1915(c) waiver services, distinct from Title XIX 1915(b)(3) waiver services, shall be accounted for separately and readily ascertainable and auditable. The accounting system shall separately maintain records pertaining to the services and any other costs and expenditures made under this Contract separately for each funding stream.

The PIHP and any subcontractors shall make available to the State, its agents, and appropriate federal representatives, any financial records of the PIHP or subcontractors on a quarterly basis. Accounting procedures, policies and records shall be completely open to State and federal audit at any time during the Contract Period and for six years thereafter.

The Contract awarded by the State and all subcontractors shall include a provision that CMS, the HHS awarding agency, the US Comptroller General, HHS Inspector General, or any authorized federal representatives, shall have access to any books, documents, papers, and records of the PIHP or subcontractors which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives has the right of timely and unrestricted access to any books, documents, papers, or other records of the PIHP or subcontractors that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to the subcontractors' personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

Independent Audit:

The PIHP shall submit an annual independently audited financial report that specifies the PIHP's financial activities under the Contract within 6 months following the end of the fiscal year. The report should be sent to the DHH Division of Fiscal Management (DFM).

The report, prepared using GAAP or Statutory Accounting Principles as designated by the National Association of Insurance Commissioners (NAIC), must be prepared by an independent Certified Public Accountant selected from a list maintained by the Office of Legislative Auditor on a calendar year basis. The PIHP shall send one copy of the report to the OBH, DFM, and the Office of the Legislative Auditor. The PIHP is responsible for the cost of the audit.

The format and contents of the audit shall be negotiated by the OBH and the PIHP, but shall include at a minimum:

i. Balance Sheet,
ii. Income Statement,
iii. Statement of Cash Flows,
iv. Statement of Retained Earnings,
v. Notes and/or Footnotes to the Financial Statement

In addition to the audited financial statement requirements, OBH will prior approve a format for additional reporting requirements that will provide information regarding the following information that will be submitted no less than annually but may include quarterly and/or monthly reporting requirements.

1. A separate accounting for all revenues received from each of the reimbursement sources in the Contract (Title XIX, SED waiver, 1915(b)(3), administration, etc.);
2. Title XIX payments and non-risk Medicaid mental health payments;
3. Third party liability payment made by other third-party payers;
4. Receipts received from other insurers;
5. A breakdown of the costs of service provision, administrative support functions, plan management including documentation of the PIHP's compliance; and
6. Assessment of the PIHP's compliance with financial requirements or the Contract including compliance with requirements for insolvency protection surplus funds, working capital, and any additional requirements; and a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

The PIHP will be required to comply with other prescribed compliance and review procedures. In addition to the annual audit, the PIHP shall be required to submit to the OBH copies of the quarterly NAIC financial reports. A final reconciliation shall be completed by the independent auditing firm that conducted the annual audit. The final reconciliation shall make any required adjustments to estimates included in the audit completed within six months of the end of the Contract year. The final reconciliation shall be completed no later than twelve months following the end of the Contract year.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA1: Number and percent of paid claims that are coded according to the services rendered

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		+,-5%
☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: PIHP	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA2: Number and percent of claims that paid at the Medicaid-approved rate in effect on the date the waiver service was rendered

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: PIHP	☐ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
OBH reviews and analyzes aggregated financial accountability performance measure data to ensure compliance with the sub-assurance. If compliance falls below 100% for performance measure FA2, OBH will require the PIHP to complete a quality improvement plan which includes a root-cause analysis, proposed interventions and associated timelines to improve performance, and methods and associated timelines for evaluating the success of the plan. If compliance falls below 86% for performance measure FA1, OBH will require the PIHP to complete a quality improvement plan inclusive of the elements stated above.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: PIHP	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The PIHP will reimburse providers no less than the rate on file by Medicaid. The Medicaid fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual practitioners. The fee schedule and any annual/periodic adjustments to the fee schedule are published on www.ldh.louisiana.gov; Public notice is made consistent with Louisiana policy as required by CMS.

Sections 953 and 954 of the Louisiana Administrative Procedure Act (APA) describes the procedures governing the adoption, amendment and repeal of an administrative Rule as well as the filing and taking effect of Rules. The promulgation of an Emergency Rule (ER) or a Notice Of Intent (NOI) is one venue of public notice of a proposed change and is recognized as such by CMS. ERs and NOIs are published in the state's official journal, the Louisiana Register, on the 20th of the month.

The APA requires that a public hearing be conducted between 35 and 40 days following the publication of a NOI in the Register. Interested parties are permitted to give oral testimony or written comments at the hearing regarding the proposed Rule. An oversight report must be submitted to the applicable legislative committee containing a copy of the original or revised NOI (only non-substantive revisions can be made), written comments received and our responses, a roster of attendees and hearing certification. Louisiana must wait 30 days after the submission of the oversight report to afford the committee an opportunity to conduct hearings before we can proceed to finalize the Rule.

The fee development methodology was primarily composed of provider cost modeling, though Louisiana provider cost data and fees from similar State Medicaid programs were considered as well. The following list outlines the major components of the cost model that was used in fee development.
-Staffing Assumptions and Staff Wages
-Employee-Related Expenses
-Benefits
-Employer Taxes (e.g., FICA, unemployment, and workers compensation)
-Program-Related Expenses (e.g., supplies)
-Provider Overhead Expenses
-Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services are submitted directly by waiver provider(s) to the PIHP. The PIHP is required per contract to submit encounters to the State MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

When an individual has been determined to be eligible for the waiver, the PIHP sends notification to DHH or its designee.

An electronic medical record or plan of care (POC) is developed for all participants served through the waiver. All waiver services on the plan of care are prior-authorized by the PIHP. Communication between the Wraparound Agency and the PIHP will occur to ensure that the plan of care is received, reviewed, and approvals are processed in a timely manner as detailed below.

When a waiver service claim is submitted to the PIHP, the PIHP's system electronically checks the plan of care database and the eligibility roster to ensure the child/youth is waiver eligible for the dates of services included on the claim. In addition, the PIHP's system electronically checks the provider file to assure the provider is enrolled with the PIHP and is approved to receive Medicaid waiver payment for the date of services.

The PIHP conducts post pay reviews to validate waiver services were in fact provided as billed. This financial integrity review is included in the PIHP's fraud and abuse prevention and detection plan. This includes determining the accuracy of documentation, eligibility, services provided, and units billed.

Providers must ensure that the services are provided in accordance with the approved plan of care, maintain adequate supporting documentation of services provided and complete data entry into the PIHP's electronic health record and database that captures services provided.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

The PIHP contract for children/youth services utilizes a non-risk-based payment methodology and requires the PIHP to obtain an independent audit that reconciles all payments, including waiver payments, with the invoices and encounter data. The Medicaid fee schedule used to establish the invoices is equal to or less than the maximum allowable under the same Medicare rates, if applicable. If a service has no Louisiana-specific Medicare rate, Louisiana has established pricing based on similar services. Room and board costs are not included in the per member per months payments for the Title XIX members.

The PIHP payments are as outlined in the contract. The payment may be adjusted based on applicable program changes, trend, etc. after each reconciliation. The final payment for 1915(c) services will not exceed what would have been paid had the same services been provided under the 1915(c) SED waiver. The OBH fiscal staff closely monitors this process for accuracy.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver

services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

No waiver services are excluded from the PIHP

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-

3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

State and local behavioral health clinics may enroll as a qualified provider to provide any services under the waiver if they meet waiver provider qualification requirements.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

○ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

◉ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

The PIHP is paid on a non-risk basis for services provided to children/youth. The federal share of any funds returned to the state as a result of the reconciliation are returned to the federal government.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ( ) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- (●) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid**

ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The risk payments to the PIHPs are based on expenditures for services in the FFS waiver. FFS payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources are used by the State and local governments to pay for room and board in licensed residential facilities.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ **Nominal deductible**
☐ **Coinsurance**
☐ **Co-Payment**
☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	4989.00	10498.00	15487.00	6121.00	10838.00	16959.00	1472.00

2	4989.00	11121.00	16110.00	6397.00	11701.00	18098.00	1988.00
3	4989.00	11784.00	16773.00	6685.00	12635.00	19320.00	2547.00
4	4989.00	12491.00	17480.00	6985.00	13393.00	20378.00	2898.00
5	4989.00	13241.00	18230.00	7300.00	14197.00	21497.00	3267.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	2400	2398	2
Year 2	2400	2398	2
Year 3	2400	2398	2
Year 4	2400	2398	2
Year 5	2400	2398	2

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay on the waiver is estimated at 9 months or 270 days. This estimate is based on the ALOS for similar waivers in other states (KS and MD).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Costs for waiver services are based on utilization projections for the waiver services and estimates of the rates to be paid for each service. The utilization projections are based on the utilization of similar services in other state waiver programs. The rates are based on modeling of the rates considering the typical compensation for workers in Louisiana. Finally, the estimated number of users of each service is based on information from other states related to the portion of the waiver population utilizing each waiver service.

Projections for years two through five incorporate considerations for utilization and cost trends of

approximately 3% annually.

Effective 3/1/14, the service rates for the peer support and parent support and training have been updated based on actual experience of the providers in LA. The utilization assumptions have also been updated for these services resulting in similar overall cost per user figures for Factor D.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on the historical utilization of other Medicaid State Plan services by children with SED. These costs are deemed a reasonable proxy for the other Medicaid costs for the waiver population.

Costs are projected based on trends in the historical data for Medicaid BH and PH services.

No children that incurred pharmacy expenses were dually eligible. Therefore, no adjustment was necessary for Medicare Part D.

Factor D' and Factor G' are very close for this initial waiver application. This is primarily due to the fact that the institutional level of care of inpatient psychiatric hospital has shorter lengths of stay than other levels of care in other 1915(c) waivers and the children that utilize inpatient psychiatric hospitals still access a number of services in the community after their hospital stays.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on the costs and utilization of children served in an inpatient hospital for psychiatric treatment or a nursing facility for mental health. This includes psychiatric units of general hospitals as well as freestanding psychiatric hospitals and nursing facility stays for children with primary diagnoses of mental health. These costs are summarized from historical FY09 FFS data. During FY09, 12 inpatient stays for children were not captured in the FFS claims data. These stays totaled approximately $900,000 and were paid in lump-sums to the hospitals. We included these Medicaid children and costs in the calculation of Factor G and G'. To project the costs into the waiver years, we projected using a 4.5% inflation factor. Any child enrolled in another 1915(c) waiver was excluded from this data.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on the historical utilization of other Medicaid State Plan services by children who used inpatient psychiatric services or nursing facility for mental health. Actual costs for other State Plan services were summarized in this analysis from FY09 data. Any child enrolled in another 1915(c) waiver was excluded from this data.

Costs are projected based on trends in the historical data for Medicaid BH and PH services.

No children that incurred pharmacy expenses were dually eligible. Therefore, no adjustment was necessary for Medicare Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Independent Living/Skills Building
Parent Support and Training
Short-Term Respite
Youth Support and Training

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2354625.00**
Independent Living/Skills Building	☐	15 minute	875	345.00	7.80	**2354625.00**	
Parent Support and Training Total:							**3600466.50**
Group	☐	15 minute	385	30.00	3.23	**37306.50**	
Individual	☐	15 minute	2400	115.00	12.91	**3563160.00**	
Short-Term Respite Total:							**193050.00**
Short-Term Respite	☐	15 minute	180	275.00	3.90	**193050.00**	
Youth Support and Training Total:							**5826517.50**
Group	☐	15 minute	650	45.00	3.23	**94477.50**	
Individual	☐	15 minute	2400	185.00	12.91	**5732040.00**	
					GRAND TOTAL:		**11974659.00**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		11974659.00
					Total Estimated Unduplicated Participants:		**2400**
					Factor D (Divide total by number of participants):		**4989.00**
					Services included in capitation:		
					Services not included in capitation:		4989.00
					Average Length of Stay on the Waiver:		270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-

l Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2354625.00**
Independent Living/Skills Building	☐	15 minute	875	345.00	7.80	**2354625.00**	
Parent Support and Training Total:							**3600466.50**
Group	☐	15 minute	385	30.00	3.23	**37306.50**	
Individual	☐	15 minute	2400	115.00	12.91	**3563160.00**	
Short-Term Respite Total:							**193050.00**
Short-Term Respite	☐	15 minute	180	275.00	3.90	**193050.00**	
Youth Support and Training Total:							**5826517.50**
Group	☐	15 minute	650	45.00	3.23	**94477.50**	
Individual	☐	15 minute	2400	185.00	12.91	**5732040.00**	

GRAND TOTAL:	**11974659.00**
Total: Services included in capitation:	
Total: Services not included in capitation:	11974659.00
Total Estimated Unduplicated Participants:	**2400**
Factor D (Divide total by number of participants):	**4989.00**
Services included in capitation:	
Services not included in capitation:	4989.00
Average Length of Stay on the Waiver:	270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2354625.00**
Independent Living/Skills Building	☐	15 minute	875	345.00	7.80	**2354625.00**	
Parent Support and Training Total:							**3600466.50**

Group	☐	15 minute	385	30.00	3.23	37306.50	
Individual	☐	15 minute	2400	115.00	12.91	3563160.00	
Short-Term Respite Total:							193050.00
Short-Term Respite	☐	15 minute	180	275.00	3.90	193050.00	
Youth Support and Training Total:							5826517.50
Group	☐	15 minute	650	45.00	3.23	94477.50	
Individual	☐	15 minute	2400	185.00	12.91	5732040.00	

GRAND TOTAL:	11974659.00
Total: Services included in capitation:	
Total: Services not included in capitation:	11974659.00
Total Estimated Unduplicated Participants:	2400
Factor D (Divide total by number of participants):	4989.00
Services included in capitation:	
Services not included in capitation:	4989.00
Average Length of Stay on the Waiver:	270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2354625.00
Independent Living/Skills Building	☐	15 minute	875	345.00	7.80	2354625.00	
Parent Support and Training Total:							3600466.50
Group	☐	15 minute	385	30.00	3.23	37306.50	
Individual	☐	15 minute	2400	115.00	12.91	3563160.00	
Short-Term Respite Total:							193050.00
Short-Term Respite	☐	15 minute	180	275.00	3.90	193050.00	
Youth Support and Training Total:							5826517.50
Group	☐	15 minute	650	45.00	3.23	94477.50	
Individual						5732040.00	

	☐	15 minute	2400	185.00	12.91		
					GRAND TOTAL:		**11974659.00**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		11974659.00
					Total Estimated Unduplicated Participants:		**2400**
					Factor D (Divide total by number of participants):		**4989.00**
					Services included in capitation:		
					Services not included in capitation:		4989.00
					Average Length of Stay on the Waiver:	270	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2354625.00**
Independent Living/Skills Building	☐	15 minute	875	345.00	7.80	**2354625.00**	
Parent Support and Training Total:							**3600466.50**
Group	☐	15 minute	385	30.00	3.23	**37306.50**	
Individual	☐	15 minute	2400	115.00	12.91	**3563160.00**	
Short-Term Respite Total:							**193050.00**
Short-Term Respite	☐	15 minute	180	275.00	3.90	**193050.00**	
Youth Support and Training Total:							**5826517.50**
Group	☐	15 minute	650	45.00	3.23	**94477.50**	
Individual	☐	15 minute	2400	185.00	12.91	**5732040.00**	
					GRAND TOTAL:		**11974659.00**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		11974659.00
					Total Estimated Unduplicated Participants:		**2400**
					Factor D (Divide total by number of participants):		**4989.00**
					Services included in capitation:		
					Services not included in capitation:		4989.00
					Average Length of Stay on the Waiver:	270	